Form 103
Adopted 1/ 1/97

**KENTUCKY**
**DEPARTMENT OF WORKERS CLAIMS**
**Application for Resolution of Hearing Loss Claim**
**Claim No. _____**

**Plaintiff**

**Social Security Number**

**Birth Date**

**Street Address**

**City/County**

**State/Zip Code**

**Phone Number**

**Alternate Phone Number**

**Representative for Plaintiff**

**Street Address**

**City/State/Zip Code**

**Phone Number**

**vs.**

**Defendant/Employer**

**Street Address**

**City/State/Zip Code**

**Insurance Carrier**

**Street Address**

**City/State/Zip Code**

**Other Defendant**

**Street Address**

**City/State/Zip Code**

**Reason for Joinder:**

**FILED:**

Do Not Write In This Space

**Other Defendant**

**Street Address**

**City/State/Zip Code**

**Reason for Joinder:**

## I. Nature of Injury

1. Plaintiff states that on_____, he/she sustained or became disabled due to occupational hearing loss within the scope and course of employment with defendant employer at : _____

   _____
   (City/County/State)

2. State the date and means by which the plaintiff gave notice of injury to the employer:

   _____

3. Describe how the injury occurred: _____

4. Describe medical treatment, if any: _____

5. Name and address of physician whose report is attached: _____

## II. Personal Data

6. Highest grade completed in school: _____

7. GED awarded: ___ yes ___ no

8. Professional or vocational degrees, certificates, or licenses: _____

9. Dependents:

| Name | Social Security Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

10. Have you previously filed for or received workers' compensation benefits? _ __yes _ __no

    If yes, give dates and nature of injury or disease: _____

III. Employment Data

11. Type of work performed at date of injury: _____

12. Describe the physical requirements of plaintiff's customary job: _____

13. Weekly wage at date of injury: _____ Attach copy of any proof of wages, such as paycheck stub, W-2, etc.

14. Has plaintiff returned to work? ___ yes ___no
Name and address of current employer : _____

15. Weekly wage currently earned: _____. Attach copy of any proof of current wages.

16. A dispute exists between the parties as to:
__ The defendant(s) liability for compensation
__ The amount or duration of benefits
__ Other (describe) _____

**Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.**

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the _____ day of _____19__.

_____
**Plaintiff's Signature**

Subscribed and sworn to before me this the _____ day of _____19__.

_____
**Notary Public**

My Commission expires: _____ County: _____ _____

Prepared and submitted by: _____
**Signature/Representative for Plaintiff**

_____**Title**

_____
**Address**

_____
**Phone Number**

# Instructions for
# Completion of Forms 101, 102 and 103

## Form 101 - Application for Resolution of Injury Claim

**1.** All sections of this form must be completed, and must be accompanied by the following:
- a. Form 104 (Plaintiff's Employment History)
- b. Form 105 (Plaintiff's Chronological Medical History)
- c. Form 106 (Medical Waiver and Consent)
- d. Medical report describing and supporting the injury which is the basis of the claim.
- e. Proof of Wages, including W-2's, paycheck stubs, etc.

**2.** All information must be typewritten.

**3.** File the original of this form and sufficient copies for all named defendants with the Department of Workers Claims, 1270 Louisville Road, Perimeter Park, Building C, Frankfort, Kentucky, 40601.

**4.** If you have no telephone number, please list a number at which you may be contacted.

**5.** If you have questions, call 1-800-554-8601

## Form 102 - Application for Resolution of Occupational Disease Claim, and Form 103 - Application for Resolution of Hearing Loss Claim

**1.** All sections of this form must be completed, and must be accompanied by the following:
- a. Form 104 (Plaintiff's Employment History)
- b. Form 105 (Plaintiff's Chronological Medical History)
- c. Form 106 (Medical Waiver and Consent)
- d. Medical report supporting the occupational disease
- e. Proof of Wages, including W-2's, paycheck stubs, etc.
- f. Social Security earnings record release form.

**2.** This form may be filed in combination with an Application for Resolution of Injury Claim (Form 101) if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.

**3.** All information must be typewritten.

**4.** File the original of this form and sufficient copies for all named defendants with the Department of Workers Claims, 1270 Louisville Road, Perimeter Park, Building C, Frankfort, Kentucky, 40601.

**5.** If you have questions, call 1-800-554-8601

**Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.**

Revised June, 2000